

How to Complete the HCFA-1500 Claim Form

Refer to HRSA's current *General Information Booklet* for instructions on completing the HCFA-1500 claim form.

You may download this booklet from HRSA's website at:

<http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html> or request a paper copy from the Department of Printing (see *Important Contacts* section).

Instructions Specific to Physicians

Field Number	Instructions
24B	See Section J for correct place of service codes. These are the only appropriate place of service codes.
24D	Enter the appropriate procedure code for the services being billed. See the fee schedule in the Appendix. Modifier: When appropriate enter a modifier from the list found in Section L.
24H	When billing the department for one of the EPSDT screening procedure codes, enter an X in this field.

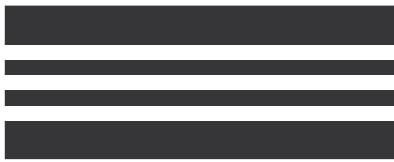
How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

For services paid for and/or applied to the deductible by Medicare:

- Complete the claim form as if billing for a non-Medicare client.
- Always attach the Medicare EOMB.
- Enter **only** payments by a third party (e.g. Blue Cross) supplement plan in field 29 and attach the Explanation of Benefits (EOB).

Note: If you are billing for services Medicare has denied, you must use a separate claim form.

PLEASE
DO NOT
STAPLE
IN THIS
AREA



SAMPLE

APPROVED OMB-0938-0008

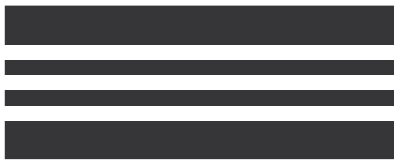
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) MJ070160SMITHA																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, MARY, J										3. PATIENT'S BIRTH DATE MM DD YY 07 01 60 SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street) 5555 NEVERENDING ROAD										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY ANYWHERE										STATE WA										CITY										STATE																													
ZIP CODE 98000										TELEPHONE (Include Area Code) ()										ZIP CODE										TELEPHONE (INCLUDE AREA CODE) ()																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME																													
c. EMPLOYER'S NAME OR SCHOOL NAME										d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 461.0 3. _____ 2. 465.0 4. _____										23. PRIOR AUTHORIZATION NUMBER																																																	
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE										1 11 01 06 11 01 06 11 99201 1, 2 5000 1																																																	
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. \$ TOTAL CHARGE 5000										29. \$ AMOUNT PAID										30. \$ BALANCE DUE 5000									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # JAMES W WILLIAMS 1500 N MADISON ANYTOWN WA 98926 (360) 777-8888 PIN# _____ GRP# 1234567																																							

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SAMPLE

Medicare Crossover

APPROVED OMB-0938-0008

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) MJ070160SMITHA									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, MARY, J										3. PATIENT'S BIRTH DATE MM DD YY 07 01 60 SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 5555 NEVERENDING ROAD										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY ANYWHERE					STATE WA					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)				
ZIP CODE 98000					TELEPHONE (Include Area Code) ()					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE					11. INSURED'S POLICY GROUP OR FECA NUMBER				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
c. EMPLOYER'S NAME OR SCHOOL NAME										d. INSURANCE PLAN NAME OR PROGRAM NAME									
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
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19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
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1 11 01 06 11 01 06 11 99201 1, 2 5000 1																			
2																			
3																			
4																			
5																			
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SIGNED _____ DATE _____										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # JAMES W WILLIAMS 1500 N MADISON ANYTOWN WA 98926 (360) 777-8888 PIN# _____ GRP# 1234567									